Meeting of the Head and Neck Cancer Clinical Advisory Group (CAG)
Tuesday 15th September 2020, 13:00-17:00, WebEx Meeting

Chair: Mr Ceri Hughes (CH)

	NOTES	ACTIONS

1. Review of last meeting's notes and actions

As there were no amendments or comments following distribution of the notes from the meeting on Tuesday 10th March 2020, the notes were accepted.

Consultant Oral and Maxillofacial Surgeon Simon Whitley has joined the team in UHBW.

2. Genomic Laboratory Hub (GLH) Update

Please see the presentation uploaded on to the SWCN website

Presented by Ana Juett (AJ)

The genomic tests listed in the following National Cancer Test Directory, have been funded centrally since April 2020: previously funded by individual provider Trusts; https://www.england.nhs.uk/publication/national genomic test directories/

All requests will be processed through one of the 7 regional genomic laboratory hubs, which for SWAG is via the South West GLH based in Severn Laboratory Bristol and Royal Devon and Exeter Laboratory.

There are limited options of genetic tests for head and neck cancer at present; any specialist tests identified as available in other national centres can be referred on via the SW GLH. However, testing for DPYD genetic variants is available, which can be used to predict DPD deficiency and identify those patients who will be at increased risk of 5-flourouracil (5-FU) or capecitabine toxicity, so that doses can be adjusted accordingly.

An EDTA blood sample and electronic referral form, found here: https://www.exeterlaboratory.com/genetics/prediction-of-5-fluorouracil-toxicity/ needs to be sent to RD&E. Turnaround time for results is approximately 7-10 days and the aim is to reduce this to 5 days. Eventually DPYD tests will be processed in the Bristol laboratory.

Action 013/20: A Juett will forward the GLH slides to H Dunderdale for circulation	**A Juett / H Dunderdale**

As 5-FU toxicity has not been found in 30% of patients treated in the BHOC to date, as reported in the presentation, there is some concern about adjusting doses based on the results of the genetic test.

Requests for DPYD tests have been routinely sent by the RUH team to the laboratory at Guys and St. Thomas's over the last 18 months, most frequently for patients with colorectal cancer rather than head and neck cancer; this has had a

significant impact, reducing admission rates due to toxicities, and concerns about undertreating have been offset by the reduced risk of side effects. The main concern with the new pathway is the increased turnaround time, as this had been reported as 10 days, whereas the turnaround time for Guys and St Thomas's is 3-5 days, and there is a reluctance to switch to a slower service.

SW GLH are working on improving turnaround time as, at some time in the future, there will not be the option to send requests to a different laboratory. All GLHs will be monitored according to the same standards across England.

Action 014/20: Consultant Oncologist Emma De Winton will consider compiling data on admissions pre and post DPYD testing to present at CAG and/or BAHNO. **E De Winton**

3. Clinical Opinion on Network Issues

3.1 Multi-Disciplinary Team Service: Changes in Light of COVID-19

Please see the presentation uploaded on to the SWCN website

Presented by Ceri Hughes (CH)

Prior to the COVID-19 pandemic, assessment of the Head & Neck MDT meeting using the validated tool MDT-Mode, resulted in a list of suggestions for potential improvements, including practical changes to the radiology lecture theatre room normally used by the team:

- Rearrangement of microphones to optimise the sound quality for RUH team
- Sound proofing to reduce noise from adjacent room
- Conference table that can be arranged U shape to get rid of the back row.

There is some funding available from the CAG service which could be used to make the changes.

Since the pandemic, the MDT meeting has moved to virtual via WebEx, and the lecture theatre has not been used, although it has been risk assessed as safe for 9 people to attend and comply with social distances. It is not possible to use the air conditioning at present and, given the concerns about moving to a hybrid system with a small group meeting face to face and the rest of the team online, the MDT will continue in its current format, which is working really well, until the new year, when the situation will be reviewed again.

Action 015/20: Consultant Radiologist Mandy Williams will investigate if the room partition can be removed to increase the number of people who are able to attend, and discuss other room improvements with C Hughes. **M Williams**

There is a need for investment in a microphone and noise cancelling headset or earpiece for all MDT members to attach to their laptops. **MDT Intervention**

4. Clinical Guidelines

4.1 Follow Up Imaging for Head and Neck Patients

Please see the presentation slide uploaded on to the SWCN website.

Presented by Matt Beasley (MB)

As discussed at the last meeting, the proposed change to post-treatment imaging of cases treated with a surgical excision of T3-T4 or N+ with or without adjuvant radiotherapy, from MRI at 3 months to MRI at 4 months, is agreed by CAG. **AGREED**

The proposed change to follow up of cases that have had (chemo) radiotherapy as the primary treatment, from PET-CT and MRI at 3 months, to PET-CT at 4 months post treatment is agreed by CAG. **AGREED**

If the PET-CT for cases post (chemo) radiotherapy is equivocal, an MRI scan will be performed if the primary site is positive, and a neck ultrasound if there is residual nodal update. **AGREED**

The new follow up schedule will be communicated to all new patients and existing patients where the CNS team think it is appropriate. **CNS team**

4.2 Dynamic Risk Stratification Post Radioiodine for Thyroid Cancer

Please see the presentation slide uploaded on to the SWCN website.

Presented by Matt Beasley (MB) and W Owadally (WO)

The British Thyroid Association (BTA) Guidelines on Dynamic Risk Stratification aim to individualise treatments by looking at thyroglobulin (Tg) and neck ultrasound at 9-12 months to determine the Thyroid Stimulating Hormone (TSH) target for follow up, and assess the risk of relapse.

Patients receive 2 intramuscular injections of TSH on Day 1 and Day 2 (generally at 9 months post treatment in UHBW), followed by a neck ultrasound Tg assessment on Day 5.

Results determine the response group allocated to the patient: Excellent, Indeterminate or Incomplete, which then informs the follow up schedule. Further details are documented within the presentation. Patients will have been prepared for the different types of response that may be expected prior to the follow up scan.

Not having to suppress TSH in some patients is the most significant change that the guidance provides which, up until this point, was done for everyone for life, and can result in unpleasant side effects.

Guidelines from the American Thyroid Association (ATA) differ slightly by looking at rises in anti-Thyroglobulin antibodies which, although not mentioned in the BTA guidelines, can help determine which patients should be categorised in the Indeterminate group.

Further details on Tg, the assays used to detect this, and the algorithms followed to detect recurrence, are within the presentation.

Action 016/20: Radiology colleagues are asked to standardise reporting of US according to the Excellent, Indeterminate and Incomplete response definitions. **M Williams / Radiology Colleagues**

US scans are often equivocal and the majority of reports are expected to fall into the Indeterminate group at first.

Current guidance is to discharge patients from follow up after 10 years. Nurse led follow up can commence after 5 years for stable patients.

Updated NICE guidelines are expected in December 2020. **Future agenda item.**

4.3 Current Guidelines for Metastatic Skin Cancer to Parotid

Please see the presentation uploaded on to the SWCN website.

Presented by Etienne Botha (EB)

Consultant Oncologist Amar Challapalli (AC) asked for the opinion of the Head and Neck CAG on surgical management of the parotid for metastatic skin cancer, to facilitate planning of subsequent radiotherapy. It is a challenging area to retreat with radiotherapy should a patient relapse or get metastatic spread, and preferable to avoid inclusion of the deep node which can significantly increase oropharynx toxicity.

Details from the *Non-melanoma skin cancer: United Kingdom National Multidisciplinary Guidelines* are within the presentation.

Nodal disease was noted to be particularly aggressive; surgery should be as complete as possible, and radiotherapy should include the parotid.

The cohort of skin cancer patients with this type of disease is usually older and the balance of surgical and oncological treatment will be offered with consideration of the patient's ability to tolerate the treatment.

5. Research

AC is the UK Chief Investigator for the C-POST randomised controlled trial for adjuvant immunotherapy (Cemiplimab) in Cutaneous Squamous Cell Cancer post-surgery and radiotherapy. The trial is open in UHBW and will open nationally in 3 to 4 other sites. Eligible patients will have high risk features including extracapsular invasion. Those randomised to receive Cemiplimab will have injections every three weeks for one year following radiotherapy. C-POST needs teams to identify eligible patients shortly after surgery to facilitate enrolment. Patients can be treated for radiotherapy at their local centre, but would need to travel to receive the trial drug.

6. Patient Experience

6.1 National Cancer Patient Experience Survey (NCPES) Results 2019

Please see the presentation uploaded on to the SWCN website.

Presented by the Clinical Nurse Specialist (CNS) Team and Lead Cancer Nurse Ruth Hendy

NCPES results, made available in June 2020, had a response rate of 66% for all cancer types across SWAG, with 120 responses for Head and Neck Cancer. UHBW had 54 responses, which is the best response rate achieved by the team to date.

Highest scores clearly indicate the excellent work undertaken to make service

improvements, including Personalised Care & Support (previously known as Living With and Beyond Cancer) activity, and access to key workers (which includes Support Workers, Allied Health Professionals and CNSs).

Lowest scores include discussion of research and care plans. The question on research scores low nationally, and is difficult to raise if there are no relevant trials available. The question is also easily misunderstood as discussion of research and discussion of clinical trials is not always interpreted by patients as the same thing.

CAG request that NCPES review the inclusion of Question 47 which is misleading, as radiotherapy has a delayed effect that can occur a long time after treatment.

Action 017/20: R Hendy sits on the NCPES advisory board and will raise the concern over the wording of the radiotherapy question. **R Hendy**

The current survey does not include the whole pathway, as patients only seen in outpatient appointments are not sent the survey; it is planned to change this in the next iteration of the survey, which will be redesigned for 2021.

A COVID related survey will be undertaken for 2020.

Patient Representative R Openshaw recommends that patients should be central to the discussions on redesigning the survey, and on assessment of potential local improvements, with the broadest representation possible, to which CAG agreed.

Action 018/20: To review local patient experience surveys and share learning across centres next year **CNS Team**

6.2 Outputs from Holistic Needs Assessments

Presented by the CNS Team / Ruth Hendy

The main trends identified by the Cancer Support Workers (CSWs) for patients with Head and Neck Cancer:

- Housing and social issues
- Homeless shelters
- Macmillan Grant Applications
- Transport needs (blue badges and bus passes).

The CSW team report that they have a huge amount of seamless support from the CNS team and Allied Health Professionals when clinical advice is required.

It is acknowledged that patients are far better supported with previously unmet needs now that the CSWs are part of the team.

7. Any Other Business

The Work Programme Progress Report has been circulated for review by CAG; updates on any actions completed can be sent to H Dunderdale.

Above & Beyond funding for improvements in care of cancer patients is available to the UHBW team, and can include capital costs. Proposals should be made for ideas where other funding streams are not available (such as Patient Experience). Proof of concept pilots could be included but staffing costs would not be covered.

CAG are advised to contact Ceit Scott (Deputy Divisional Director and Assistant General Manager for Surgery) for the relevant form. The Steering Group will review all proposals and allocate funding.

Due to the aerosol generating nature of dental procedures and the lack of rooms available in the Bristol Dental Hospital, the number of clinical review sessions each week has drastically reduced, which could result in delayed treatment for patients with Head & Neck cancer and dental needs. The number of patients that this may affect is unclear at present.

Action 019/20: Consultant Restorative Dentist Lisa McNally will escalate to Cancer Manager Hannah Marder, who will share with the appropriate Dental Hospital Managers. **L McNally / H Marder**

Recently, a number of referrals for neck lump US have been made to NBT, resulting in review by non-specialists, inadequate sampling, delays to the patient pathway, and an increased number of attendances. CAG want to ensure all neck lump US referrals are seen by the specialist team in UHBW. NBT radiology colleagues could be invited to do sessions with the team.

Action 020/20: H Dunderdale will contact Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group (BNSSG) to see if it is possible to remove the NBT option for US neck lump referrals. **H Dunderdale**

RUH Consultant ENT Surgeon John Waldron has now retired, and his replacement Andy Carswell, from Great Western Hospital, will join the team in the near future.

Date of next meeting: Tuesday 9th March 2021, 14:00-15:30

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